Infant WIC Precertification Application

*Please **print** all information.*

FAMILY DEMOGRAPHICS / MEMBERS

Mother's last name: _____ **Mother's** first name: _____Middle initial: ___
Mother's date of birth: ____/____/____
Baby's last name:_____ **Baby's** first name:_____Middle initial:___
Baby's date of birth: ____/____/____ **FOR WIC STAFF ONLY:** ☒ **PRE-CERTIFY** Application date: ____/____/____

CONTACT /ADDRESS

Home phone: (_____) _____ -- _____
Physical address:
Line 1: _____
Line 2: _____
City:_____ State: ___ ZIP code:_____
County: _____

Alternate phone: (_____) _____ -- _____
Mailing address (if different than physical address):
Line 1: _____
Line 2: _____
City:_____ State: ___ ZIP code:_____

FAMILY DEMOGRAPHICS / ENROLLMENT FOR BABY

Sex: ☐Male ☐Female

FOR WIC STAFF ONLY: *Select FI Issuance Period*

FAMILY ELIGIBILITY / PARTICIPANT ELIGIBILITY

Participant type: Infant
Proof of identity **for baby** *(check one):*
☐ Hospital/medical record
☐ Birth certificate

Proof of Medicaid eligibility provided: ☐Yes ☐No

☐ Crib card
☐ Medicaid card
☐ No proof due to theft, loss, disaster, or recent immigration

FAMILY ELIGIBILITY / INCOME

Number in household, including baby: ____
Proof of physical address **for family** *(check one)*:
☐ Driver's license with current address
☐ Current utility bill
☐ Rent or mortgage receipt
☐ Voter registration with current address
☐ No proof of address due to theft, loss, disaster, migrant status, a recent move, or homelessness
☐ Medicaid or other public assistance notification with current address
☐ No proof this visit

Primary source of income *(check one)*:
☐ Wages, commissions
☐ Social Security
☐ FIP
☐ Self-employment
☐ Child support
☐ Military allotment
☐ Alimony
☐ Unemployment, workers comp or strike benefits
☐ Lump sum payment
☐ Zero income

Verbal report of family income: **$ _____/month** *(This is required if you saw proof of Medicaid eligibility. If you did not see proof of Medicaid eligibility and you can document that you saw proof of income, complete the income table on the next page.)*

HEALTH & NUTRITION / BREASTFEEDING

Ever breastfed this infant? ☐ Yes ☐ No
Mother *(check one)*:
☐ Mother on WIC; see name above
☐ Mother not on WIC

Breastfeeding history for this infant:
☐ Exclusive breastfeeding since birth (including expressed breastmilk)
☐ Supplemented; date started: ____/____/____
How much/day? ____ oz.
☐ Terminated; date stopped: ____/____/____

Your Rights and Responsibilities as a WIC Participant

I understand that:

- I am encouraged to participate in the health services and nutrition education provided by my local agency.
- The standards for eligibility and participation in the WIC Program are the same for everyone, regardless of race, color, national origin, age, handicap, or sex.
- I can file a complaint if I believe I have been treated unfairly.
- I can appeal any decision made by the local agency about my eligibility.

As a WIC participant:

- I can get WIC checks from only one local agency at a time.
- I will use my WIC benefits only to buy approved WIC foods.
- I will contact my WIC agency if changes are needed to my WIC benefits.
- WIC food benefits are prescribed for the individual. It is illegal to or attempt to sell, return or exchange foods for cash or credit.
- If I violate WIC Program regulations, the WIC agency will send me a notice of violation. Accumulation of violation points may result in disqualification from the program.
- I cannot get food from the Polk County Commodity Supplemental Food Program for any family member who gets WIC benefits.
- I understand that my record can be read by staff of the Iowa Department of Public Health (IDPH).
- I understand that the director of the IDPH may authorize the sharing of my WIC information with specific health and education programs. These programs may use this information to determine my eligibility for their programs; to provide me with information about those programs and to make the application process easier; to improve my health, education or well-being if I am already enrolled in their programs; and to make sure my health care needs have been met.
- I have read or been advised of my rights and responsibilities. I have provided correct information about my eligibility for this federal program. Program officials may verify the information I provided. I know that if I lie or hide facts to get WIC foods that I am not eligible to receive, I may be required to repay the cash value of those foods and may be subject to civil or criminal prosecution under state and federal law.

Name of WIC participant certified today: _____

_____

Signature of participant/parent/guardian Date

_____

Signature of local agency official Date

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Family Eligibility / Income **(continued)**

Complete if you did not see proof of Medicaid eligibility AND you can document that you saw proof of income.
If the applicant does not have proof of income, give her the form and the phone number so she can make a WIC appointment.

Income source	Circle documentation seen	How much Before deductions	How often Weekly;, bi-weekly (every 2 weeks); Semi- monthly (twice/month); monthly; annual
Wages, commissions	Check stub, employer statement		
Wages, commissions	Check stub, employer statement		
Wages, commissions	Check stub, employer statement		
Social security	Check stub, award notice		
FIP	Award notice		
Self-employment	Tax return, business records		
Child support	Award notice, check stub, tax return		
Military allotment	Check stub		
Alimony	Award notice		
Unemployment, Workers Comp or strike benefits	Award notice, check stub		
Lump sum payment	Award notice, check stub		
Zero income	---	**0**	---

HEALTH

Was mother ON WIC during her pregnancy? ☐ Yes; skip to **FOOD PACKAGE** ☐ No; continue to next question

If NOT ON WIC during pregnancy, check all the risks she had during her pregnancy:

- ☐ Alcohol or drug use +
- ☐ Anemia
- ☐ Close pregnancies (<16 mo)
- ☐ Gestational diabetes
- ☐ High maternal weight gain
- ☐ Hx of preterm (≤37 wks) or LBW baby (≤5 ½ lb)
- ☐ Hx of stillbirth, fetal or neonatal loss
- ☐ Hx of ≥2 miscarriages before 20 wks gestation
- ☐ Lack of prenatal care (1st visit after 13 wks or <4 visits total)
- ☐ Low maternal weight gain
- ☐ Multifetal gestation
- ☐ Other nutrition-related condition affecting nutritional status (list): _____
- ☐ ≤17 yrs old at time of conception
- ☐ Pre-pregnancy BMI <18.5
- ☐ Pre-pregnancy BMI ≥25.0
- ☐ Smoking during pregnancy
- ☐ Weight loss during pregnancy

(BMI = [wt (lb) ÷ ht (in) ÷ ht (in)] X 703)

+ Release of this information is protected by law; mail a copy of the signed release to the WIC agency.

FOOD PACKAGE (IF NEEDED)

- ☐ Similac Advance *(circle one)*: Conc. Powder
- ☐ Gerber Good Start Soy (*circle one):* Conc. Powder

Directions for eWIC card:
- ☐ Mail
- ☐ Will pick up at WIC

APPLICANT SIGNATURE *(must also review and sign the back of page 1)*

I understand that my baby must complete a certification appointment at the WIC office in order to continue receiving benefits.

_____
Signature of parent/guardian Date

REFERRAL AGENCY SIGNATURE

The information on this form is complete and accurate to the best of my knowledge.
Food benefit education was provided by (*check one*): ☐ Video ☐ Flip chart ☐ Currently on WIC

_____
Signature & title Agency Phone # Date

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